		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041178

Facility Name: Riverview, A Sr. Lvg Community

Address: 500 Centennial Drive (Number) East Peoria (City) 61611 (Zip Code)

County: Tazwell

Telephone Number: (309) 694-0022 **Fax #** (309) 694-3655

HFS ID Number: 520886946023

Date of Initial License for Current Owners: 10/03/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/04 to 05/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	61	Skilled (SNF)	61	22,265	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	61	TOTALS	61	22,265	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	757	8,234	11,591	20,582	8
9	SNF/PED					9
10	ICF	378			378	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,135	8,234	11,591	20,960	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.14%

D. How many bed-hold days during this year were paid by the Department? 6 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/03/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/03/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 61 and days of care provided 7,519

Medicare Intermediary Care First of Maryland, Inc

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/05 Fiscal Year: 05/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	321,911	1		321,912	1,560	323,472		323,472			1
2	Food Purchase		12,777		12,777		12,777	(341)	12,436			2
3	Housekeeping	83,744	6,732	2,282	92,758		92,758		92,758			3
4	Laundry	38,774	8,949	297	48,020		48,020		48,020			4
5	Heat and Other Utilities			107,996	107,996	3,599	111,595	(2,516)	109,079			5
6	Maintenance	36,098	7,643	23,352	67,093		67,093		67,093			6
7	Other (specify):* **Medical Waste**			782	782		782		782			7
8	**TOTAL General Services**	480,527	36,102	134,709	651,338	5,159	656,497	(2,857)	653,640			8
	B. Health Care and Programs											
9	Medical Director			5,175	5,175		5,175		5,175			9
10	Nursing and Medical Records	1,200,336	102,569	59,360	1,362,265	26,613	1,388,878		1,388,878			10
10a	Therapy	263,470	3,669	194,544	461,683		461,683		461,683			10a
11	Activities	37,282	2,271	1,565	41,118		41,118		41,118			11
12	Social Services	94,866	502	1,105	96,473		96,473		96,473			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,595,954	109,011	261,749	1,966,714	26,613	1,993,327		1,993,327			16
	C. General Administration											
17	Administrative	80,184		208,969	289,153	(66,880)	222,273		222,273			17
18	Directors Fees											18
19	Professional Services			3,807	3,807		3,807	(3,807)				19
20	Dues, Fees, Subscriptions & Promotions			49,183	49,183		49,183	(33,094)	16,089			20
21	Clerical & General Office Expenses	110,266	32,843	48,629	191,738		191,738	(40,671)	151,067			21
22	Employee Benefits & Payroll Taxes			440,848	440,848	24,467	465,315		465,315			22
23	Inservice Training & Education			1,659	1,659		1,659		1,659			23
24	Travel and Seminar			17,155	17,155		17,155		17,155			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			71,127	71,127		71,127		71,127			26
27	Other (specify):*											27
28	**TOTAL General Administration**	190,450	32,843	841,377	1,064,670	(42,413)	1,022,257	(77,572)	944,685			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,266,931	177,956	1,237,835	3,682,722	(10,641)	3,672,081	(80,429)	3,591,652			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Riverview, A Sr. Lvg Community #0041178 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			216,521	216,521	10,641	227,162		227,162			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(56)	(56)		(56)		(56)			32
33	Real Estate Taxes			97,672	97,672		97,672	(52,656)	45,016			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			27,324	27,324		27,324		27,324			35
36	Other (specify):*											36
37	**TOTAL Ownership**			341,461	341,461	10,641	352,102	(52,656)	299,446			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		358,354	101,921	460,275		460,275		460,275			39
40	Barber and Beauty Shops			24,952	24,952		24,952		24,952			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,399	33,399		33,399		33,399			42
43	Other (specify):* **Therapy Drugs**		22,155		22,155		22,155		22,155			43
44	**TOTAL Special Cost Centers**		380,509	160,272	540,781		540,781		540,781			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,266,931	558,465	1,739,568	4,564,964		4,564,964	(133,085)	4,431,879			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(341)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,516)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(14,154)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,807)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,166)	21		24
25	Fund Raising, Advertising and Promotional	(33,094)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(52,656)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(351)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (133,085)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (133,085)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Riverview, A Sr. Lvg Community

ID# 0041178

Report Period Beginning: 06/01/04

Ending: 05/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Customer Reimbursement	$ (351)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(351)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(341)	0	0	0	0	0	0	0	0	0	0	(341)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,516)	0	0	0	0	0	0	0	0	0	0	(2,516)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,857)	0	0	0	0	0	0	0	0	0	0	(2,857)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,807)	0	0	0	0	0	0	0	0	0	0	(3,807)	19
20	Fees, Subscriptions & Promotions	(33,094)	0	0	0	0	0	0	0	0	0	0	(33,094)	20
21	Clerical & General Office Expenses	(40,671)	0	0	0	0	0	0	0	0	0	0	(40,671)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(77,572)	0	0	0	0	0	0	0	0	0	0	(77,572)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(80,429)	0	0	0	0	0	0	0	0	0	0	(80,429)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Riverview, A Sr. Lvg Community** **#** **0041178** **Report Period Beginning:** **06/01/04** **Ending:** **05/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(52,656)	0	0	0	0	0	0	0	0	0	0	(52,656)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(52,656)	0	0	0	0	0	0	0	0	0	0	(52,656)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(133,085)	0	0	0	0	0	0	0	0	0	0	(133,085)	45

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
	100	Health Care & Retirement Corporation	Toledo, OH			
Manor Care, Inc		of America				
		(See H.O. Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See	Home Office Allocation	$ 208,969	HCR Manor Care, Inc	100.00%	$ 208,969	$	1
2	V		Page							2
3	V		8							3
4	V									4
5	V									5
6	V		10a	Therapy Management	19,895	Heartland Management Services	100.00%	19,895		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 228,864			$ 228,864	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc
Street Address: 333 North Summit St
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	1,043,233	571,891	4,231,429	1,560	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	223,707		4,231,429	400	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	2,139,042		4,231,429	3,199	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	12,987,607	8,226,246	4,231,429	23,244	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	2,252,260	1,199,059	4,231,429	3,369	6
7	17	General & Admin - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	16,611,639	15,056,893	4,231,429	29,731	7
8	17	General & Admin - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	75,121,310	43,509,256	4,231,429	112,357	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	3,924,545		4,231,429	7,024	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	11,662,215		4,231,429	17,443	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac			4,231,429	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	7,114,804		4,231,429	10,641	12
13										13
14	32	Interest				10,002,527				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 143,082,889	$ 68,563,345		$ 208,968	25

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Riverview, A Sr. Lvg Community **#** 0041178 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	83,664	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	31,008	2
3. Under or (over) accrual (line 2 minus line 1).	$	(52,656)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	96,594	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	1,078	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	45,016	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	70,208	8
	2001	57,167	9
	2002	59,634	10
	2003	63,899	11
	2004	64,396	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Riverview, A Sr. Lvg Community COUNTY Tazwell

FACILITY IDPH LICENSE NUMBER 0041178

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-04-25-100-013	See Attached (16%)	$ 7,814.29	$ 1,250.29
2.	01-01-23-200-025	See Attached (16%)	$ 193,423.47	$ 30,947.76
3.	04-04-25-100-013	See Attached (16%)	$ 7,814.29	$ 1,250.29
4.	01-01-23-200-025	See Attached (16%)	$ 193,423.47	$ 30,947.76
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 402,475.52	$ 64,396.10

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,687 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 335,515	1
2					2
3	TOTALS			$ 335,515	3

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	59			1995	$ 2,170,148	$ 42,763		$ 42,763	$	$ 136,499	4
5	CR 5/31/99 AUDIT ADJ			2002	(802,552)						5
6	2			2003	345,836						6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)					110,703		110,703		385,972	9
10	CR 5/31/99 AUDIT ADJ			1990	2,279						10
11	CR 5/31/99 AUDIT ADJ			1993	10,497						11
12	CR 5/31/99 AUDIT ADJ			1994	975						12
13	CR 5/31/99 AUDIT ADJ			1994	3,509						13
14	CR 5/31/99 AUDIT ADJ			1995	3,969						14
15	FLOORING/CARPETING			1997	2,228						15
16	ELECTRICAL			1997	4,089						16
17	KICKPLATES			1997	2,838						17
18	HOT WATER TANK			1997	2,744						18
19	FLOORING			1997	1,825						19
20	MOTOR			1997	2,305						20
21	GAZEBO IMPROVEMENTS			1997	1,737						21
22	WALL COVERING			1997	5,337						22
23	ROOM UPGRADES			1997	37,321						23
24	SIGNS			1997	1,179						24
25	STEAMER			1997	2,587						25
26	ROOFING			1998	1,117						26
27	FLOORING			1998	4,963						27
28	CARPENTRY			1998	3,150						28
29	PLUMBING			1998	10,659						29
30	WALLCOVERING			1998	9,932						30
31	DOOR/WINDOW			1998	658						31
32	RENOVATION-PATIENT ROOMS			1998	41,798						32
33	FINISH /STUD			1998	4,351						33
34	CARPENTRY			1998	4,953						34
35	DOOR/WINDOW			1998	14,573						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FLOORING	1998	$ 6,859	$		$	$	$	37
38	PLUMBING	1998	757						38
39	ELECTRICAL	1998	7,844						39
40	PAINTING/WALLCOVERING	1998	12,790						40
41	PAINTING/WALLCOVERING	1998	11,007						41
42	ROOFING	1998	500						42
43	SIGNAGE	1998	28,202						43
44	HVAC	1998	4,530						44
45	CONCRETE SIDEWALK	1998	1,800						45
46	PAINTING/WALLCOVERING	1999	460						46
47	DINING ROOM REMODEL	1999	3,196						47
48	WALLCOVERING	2000	47						48
49	WALLCOVERING	2000	148						49
50	WALLCOVERING	2000	417						50
51	DOUBLE EGRESS DOORS	2000	2,985						51
52	JOCKEY PUMP FOR SPRINKER SYSTEM	2000	310						52
53	OFFICE REMODELING	2000	660						53
54	DINING RENOVATIONS	2000	2,169						54
55	OFFICE RENO	2000	3,064						55
56	CIRCULATING PUMP & PIPING	2000	2,814						56
57	DINING ROOM REMODELING COST	2000	540						57
58	WALLCOVERING	2000	1,689						58
59	PIPING	2000	998						59
60	PIPING COST	2000	22						60
61	ADDTL PIPING COST	2000	274						61
62	PIPING COST	2000	2,475						62
63	PIPING	2000	33,529						63
64	ADDTL COST OFFICE RENOVATION	2000	231						64
65	COUNTERTOP-OFFICE RENOVATION	2000	795						65
66	SPRINKLER WORK	2000	963						66
67	SPRINKLER WORK - RETAINAGE	2000	107						67
68	WALLCOVERING-BUSINESS OFFICES	2000	2,000						68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,029,187	$ 153,466		$ 153,466	$	$ 522,471	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,029,187	$ 153,466		$ 153,466	$	$ 522,471	1
2	BORDER - DON OFFICE	2000	30						2
3	WALLCOVERING	2000	95						3
4	CONSULTANT-DINING RM	2000	3,514						4
5	FLOORING-DINING RM	2000	1,091						5
6	FLOORING-DINING RM	2000	70						6
7	WALLCOVERING-DINING RM	2000	573						7
8	DINING RM RENOVATIONS	2000	1,540						8
9	WALLCOVERING	2000	344						9
10	DINING RM DEMO	2000	400						10
11	CONSULTING-OFFICE RENOV	2000	543						11
12	JOHNSON CONTROL COMPRESSOR	2000	1,189						12
13	ELECTRICAL	2000	3,951						13
14	ELECTRICAL-RETAINAGE	2000	439						14
15	PTAC UNITS & DUCKWORK-OFFICE	2000	16,375						15
16	DUCTWORK & WALLS-OFFICES	2000	1,819						16
17	CARPET	2000	4,652						17
18	CARPET	2000	200						18
19	ADDT'L DINING ROOM RENOVATION	2000	162						19
20	ELECTRICAL	2000	1,919						20
21	ELECTRICAL	2000	960						21
22	ADDT'L COSTS OF ROOFTOP	2001	226						22
23	CEILING-TILES LAUNDRY ROOM	2001	1,855						23
24	CEILING TILE	2001	4,985						24
25	TILE CEILING	2001	1,599						25
26	CUSTOM NURSES STATION	2001	8,469						26
27	CEILING TILE	2001	2,350						27
28	VINYL FLOOR COVERING WITH BASE	2001	1,300						28
29	RELOCATE EXHAUST FANS & GRILLE	2001	4,478						29
30	RELOCATE EXHAUST FANS & GRILLE	2001	498						30
31	PAINTING	2001	2,900						31
32	LANDSCAPING	2001	7,097						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,104,807	$ 153,466		$ 153,466	$	$ 522,471	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,104,807	$ 153,466		$ 153,466	$	$ 522,471	1
2	FIRE CAULKING AND SAFING	2002	3,886						2
3	BORDER	2002	75						3
4	DRYVIT FOR WINDOWS	2002	7,700						4
5	BORDER	2002	101						5
6	WINDOW TREATMENTS	2002	1,670						6
7	WALLCOVERING AND PAINTING	2002	171						7
8	CARPET	2002	3,542						8
9	WALLCOVERING, PAINTING	2002	1,537						9
10	VINYL WALL COVERING	2002	312						10
11	VINYL WALL COVERING	2002	276						11
12	CARPET	2003	298						12
13	VINYL WALL COVERING	2003	2,536						13
14	VINYL WALL COVERING AND BORDER	2003	858						14
15	VINYL WALL COVERING	2003	6,014						15
16	GENERAL CONTRACTING FEES	2003	73,912						16
17	ADDITIONAL COST METAL DOOR	2003	1,087						17
18	VINYL WALL COVERING AND BORDER	2003	10,700						18
19	FLOORING	2003	570						19
20	FREIGHT ON WALL COVERING	2003	105						20
21	FREIGHT ON WALL COVERING	2003	258						21
22	ADDITIONAL CONTRATOR FEES	2003	427						22
23	METAL DOOR	2003	9,782						23
24	ARCHITECT & ENGINEER COSTS	2003	52,481						24
25	GENERAL OVERHEAD	2003	169,901						25
26	INTEREST ON CONSTRUCTION	2003	19,685						26
27	CARPET AND PAD	2003	11,635						27
28	FREIGHT ON CARPET	2003	64						28
29	FREIGHT ON ARTWORK	2003	244						29
30	FLOORING	2003	10,500						30
31	CONCRETE TESTING	2003	2,407						31
32	GENERAL CONTRACTOR	2003	44,443						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,541,983	$ 153,466		$ 153,466	$	$ 522,471	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,541,983	$ 153,466		$ 153,466	$	$ 522,471	1
2	CONCRETE	2003	3,800						2
3	STEEL GUARDRAIL	2004	3,680						3
4	PATIO COVER	2004	13,695						4
5	PATIO COVER - ADDTL COSTS	2004	1,500						5
6	FREIGHT ON VINYL WALL COVERING	2004	255						6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,564,913	$ 153,466		$ 153,466	$	$ 522,471	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 959,694	$ 63,054	$ 63,054	$		$ 726,521	71
72	Current Year Purchases	57,806						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			10,641	10,641			74
75	TOTALS	$ 1,017,500	$ 63,054	$ 73,695	$ 10,641		$ 726,521	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,917,928	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 216,520	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 227,161	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,641	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,248,992	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 27,324 Description: O2 Concentrators,Wheelchairs,Gerichairs,Elect Beds, Etc
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	3086 hrs	$ 86,224	3,577	$ 89,413	$ 735	6,663	$ 176,372	1
2	Licensed Speech and Language Development Therapist	10a	673 hrs	18,802	513	12,816	213	1,186	31,831	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	5671 hrs	158,444	3,689	92,213	2,721	9,360	253,378	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				358,354		358,354	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S-Lab,X-Ray,Inhal	10, Col 3,39				102,023			102,023	13
14	TOTAL			$ 263,470	7,779	$ 296,465	$ 362,023	17,209	$ 921,958	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Riverview, A Sr. Lvg Community **#** 0041178 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (6,806)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (151,976))	1,081,425		3
4	Supply Inventory (priced at)	13,454		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,197		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,090,270	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	335,515		13
14	Buildings, at Historical Cost	2,564,912		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,017,501		16
17	Accumulated Depreciation (book methods)	(1,248,992)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,668,936	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,759,206	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 56,413	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	164,309		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	96,594		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	24,680		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 341,996	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 341,996	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,417,210	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,759,206	$	48

***(See instructions.)**

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,334,157	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,334,157	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	529,086	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 529,086	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(446,033)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (446,033)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,417,210	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,980,498	1
2	Discounts and Allowances for all Levels	(580,432)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,400,066	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,312,384	6
7	Oxygen	3,353	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,315,737	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	281	12
13	Barber and Beauty Care	14,343	13
14	Non-Patient Meals	60	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	349,538	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,506	19
20	Radiology and X-Ray	5,290	20
21	Other Medical Services	1,229	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 378,247	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,094,050	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	651,338	31
32	Health Care	1,966,714	32
33	General Administration	1,064,670	33
	B. Capital Expense		
34	Ownership	341,461	34
	C. Ancillary Expense		
35	Special Cost Centers	540,781	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,564,964	40
41	**Income before Income Taxes (line 30 minus line 40)****	529,086	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 529,086	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	981	1,068	$ 29,787	$ 27.89	1
2	Assistant Director of Nursing	3,792	4,131	108,666	26.31	2
3	Registered Nurses	3,581	3,901	95,577	24.50	3
4	Licensed Practical Nurses	22,353	24,350	499,026	20.49	4
5	CNAs & Orderlies	36,223	39,459	444,285	11.26	5
6	CNA Trainees					6
7	Licensed Therapist	8,131	8,891	248,387	27.94	7
8	Rehab/Therapy Aides	1,036	1,133	15,083	13.31	8
9	Activity Director					9
10	Activity Assistants	3,216	3,504	37,282	10.64	10
11	Social Service Workers	5,512	6,005	94,866	15.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,530	24,530	321,911	13.12	15
16	Dishwashers					16
17	Maintenance Workers	2,371	2,608	36,098	13.84	17
18	Housekeepers	8,406	9,160	83,744	9.14	18
19	Laundry	4,001	4,373	38,774	8.87	19
20	Administrator	2,619	2,619	80,184	30.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,636	8,491	110,266	12.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,164	2,364	22,995	9.73	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,552	146,587	$ 2,266,931 *	$ 15.46	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	5,175	Ln 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 5,175		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Candy White	Administrator	0	$ 80,184
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,184

B. Administrative - Other

Description	Amount
Home Office	$ 208,969
TOTAL (agree to Schedule V, line 17, col. 3)	$ 208,969
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
C Edwin Walker	Legal Fees	1,990
Van Ostrand & Elvidge Kelly	Legal Fees	1,817
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 3,807

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,805
Unemployment Compensation Insurance	33,899
FICA Taxes	143,719
Employee Health Insurance	160,834
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	4,040
Other Employee Benefits	5,567
Employee Uniforms	1,005
Payroll Overhead Allocated	(21)
Home Office Allocation	24,467
TOTAL (agree to Schedule V, line 22, col.8)	$ 465,315

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,112
Advertising: Employee Recruitment	6,053
Health Care Worker Background Check	
(Indicate # of checks performed 146)	2,918
Dues & Subscriptions	479
Association Dues	2,895
Marketing	64
Advertising	34,662
Less: Non-Allowable Association Dues	(934)
Less: Public Relations Expense	(64)
Non-allowable advertising	(32,096)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,089

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	17,155
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,155

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Riverview, A Sr. Lvg Community # 0041178 Report Period Beginning: 06/01/04 Ending: 05/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Riverview, A Sr. Lvg Community **#** 0041178 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 2,895**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $ 934**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **27,819** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **33,399**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(60)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.